

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

08301 302  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 64 years  
Hospital, institution, or street address where death occurred:  
230 Frederick St.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 230 Frederick St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.

### 3. (a) FULL NAME

Alice M. Adams

### 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Henry Adams 6.(c) If alive, give age 72 years  
7. Birth date of deceased (mo., day, yr.) January 9, 1878  
8. AGE: Years 69 Months 8 Days 11 If less than one day hrs. min.  
9. Birthplace Middletown, Fred. CO., Md.  
(Town, county, and state)  
10. Usual occupation housewife  
11. Industry or business

FATHER 12. Name Samuel S. Thompson  
13. Birthplace Adams Co., Penna.  
MOTHER 14. Maiden name Susan E. Cramer  
15. Birthplace near Smithsburg, Md.  
16. Informant Edward L. Thompson  
Address Hagerstown, Md.

17. burial Date thereof 9-24-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Rose Hill Cemetery  
Hagerstown, Md.  
Location Scott F. Minnich & Son  
18. Funeral director Hagerstown, Md.  
Address

19. Sept. 23, 1947 Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1947 11:15p M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1942 to 19  
and that I last saw her alive on Sept/1, 1947 19  
Immediate cause of death Vascular hypertension 7yrs  
Due to chr. myocardial valvular  
arteriosclerotic heart disease  
Due to 6yrs  
Other conditions acute ventricular fibrillation

(Include pregnancy within 3 months of death)  
Major findings of operations no Date of op.  
Autopsy results no  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide no Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE S. Robert Wells, M.D.  
Hagerstown, Md. M.D. or other Sept/22/47  
Address Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 25 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

C8302

303

## 1. PLACE OF DEATH:

County WASHINGTON  
 City or town RURAL - HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 WKS.  
 Hospital, institution, or street address where death occurred:  
GATE WAY NURSING HOME  
 How long in hospital or institution? 2 WKS.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTON  
 City or town HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 22 N. BTOMAC ST.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war NON-VET

## 3. (a) FULL NAME

LOTTIE CATHERINE ALTER

## 3. (b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED.  
 6. (b) Name of husband or wife JOHN E. ALTER  
 7. Birth date of deceased (mo., day, yr.) NOVEMBER 2, 1888  
 8. AGE: Years 58 Months 10 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 6. (c) If alive, give age \_\_\_\_\_ years

9. Birthplace EDGEMONT WASH., MARYLAND  
 (Town, County, and state)

10. Usual occupation HOUSEWIFE

## 11. Industry or business

FATHER 12. Name GEORGE RIDGE  
 13. Birthplace MARYLAND  
 MOTHER 14. Maiden name CLARA BELLE WILHIDE  
 15. Birthplace MARYLAND

16. Informant Mr. Marshall Moore (daughter)  
 Address 215 E. Washington St., Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 9/5/47  
 (month) (day) (year)  
 Cemetery or crematory Watts Church Cemetery  
 Location Greensburg, Md.

18. Funeral director W. J. Harment  
 Address Hagerstown, Md.

19. SEP 19 47 Fred M. Forkner  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

D.S.T.

20. DATE OF DEATH SEPTEMBER 3, 1947 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUGUST 13, 1947 to SEPT 3, 1947  
 and that I last saw her alive on SEPTEMBER 2, 1947.

Immediate cause of death

CARCINOMA OF  
RECTUM WITH  
METASTASIS

DURATION

?

Due to

Other conditions None.

(Include pregnancy within 3 months of death)

Major findings of operations SAME Approximately  
 Date of op. 1 year ago

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Archie Robert Cohen M. D. Archie Robert Cohen  
 Address Clees Spring Ford Date signed 9/3/47

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SEP 19 1947

BUREAU # 8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

08303

1700

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 years  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
D O A  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1020 Pope Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War 11

## 3. (a) FULL NAME

William F. Ankeney Jr.

## 3. (b) Social Security Number

219-12-2133

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Beulah Ankeney  
 7. Birth date of deceased (mo., day, yr.) July 15, 1924 6. (c) If alive, give age ..... years  
 8. AGE: Years 23 Months 1 Days 22 If less than one day ..... hrs. .... min.

9. Birthplace Martinsburg, W. Va.  
 (Town, county, and state)  
 10. Usual occupation Employee of Victor Products Corp.  
 11. Industry or business

FATHER 12. Name William F. Ankeney  
 13. Birthplace Clear Spring, Md.  
 MOTHER 14. Maiden name Wilma Phelps  
 15. Birthplace Waverly, New York

16. Informant William F. Ankeney Sr.  
 Address 1020 Pope Ave- Hagerstown, Md.

17. Burial Date thereof Sept. 9, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Paul's Cemetery  
 Location Near Hagerstown- Route 40 W.

18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Maryland

19. Sept. 9, 1947 Glenn H. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION EDT

20. DATE OF DEATH Sept. 6, 1947 19..... at 6:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19....., to ..... 19.....  
 and that I last saw him ..... alive on ..... 19.....

Immediate cause of death ..... DURATION  
Fractured skull (closed)  
 Due to Open fracture of left humerus  
 Due to .....  
 Other conditions .....  
 (Include pregnancy within 3 months of death)

Major findings of operations None Date of op. ....  
 Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of 9/6/47  
 Where did injury occur? Near Hagerstown Wash. Md.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) Route 40 Dual Highway  
 Means of injury Collision of motorcycle Injured at work? No  
light automobile DEPUTY MEDICAL EXAMINER  
W. H. H. Wells WASH. CO., MD.  
 23. SIGNATURE W. H. H. Wells M. D. W. H. H. Wells  
 Address Hagerstown, Md. Date signed 9/8/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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SEP 11 1947  
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Cohen

08304

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death 2 Hours  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown R # 2  
 (If outside city or town limits, write RURAL and give nearest town)  
Wilsons  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

FRANK LESLIE BLOYER

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Lillie May  
 6.(c) If alive, give age 60 years  
 7. Birth date of deceased (mo., day, yr.) September 17 1877  
 8. AGE: Years 70 Months 0 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Broadfording Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business Retired  
 12. Name Jacob Bloyer  
 13. Birthplace Broadfording Md.  
 14. Maiden name Sophia Neikirk  
 15. Birthplace Broadfording Md.

16. Informant E. Funk Bloyer  
 Address Hagerstown Md. R.F.D.  
 17. Burial Date thereof 9/27/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St/ Pauls Cemetery  
 Location near Clearspring Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Sept. 27, 1947 Charles H. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 1947 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 19, 1945 to SEPT. 25, 1947  
 and that I last saw him alive on SEPT. 25, 1947

Immediate cause of death Myocarditis. Chrmic  
Diabetes mellitus  
Cerebral hemorrhage  
 Other conditions None

(Include pregnancy within 3 months of death)  
 Major findings of operations None  
 Date of op. \_\_\_\_\_  
 Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles H. Bowers M. D. o 9/26/47  
 Address Clear Spring Md Date signed 9/26/47

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SEP 30 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

## CERTIFICATE OF DEATH

Dr. Robert Campbell

08305

247

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 Days  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 10 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 289 Fredrick St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

EUGENE EDWIN BROOKMAN

## 3. (b) Social Security Number

214-09-8288

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Gladys  
 6. (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) October 12, 1882

8. AGE: Year 65 Month 11 Days 4 It less than one day  
 hrs. min.

9. Birthplace Charlottesville, Va.  
 (Town, county, and state)

10. Usual occupation Construction Foreman

11. Industry or business City of Hagerstown

12. Name No Record

13. Birthplace No Record

14. Maiden name No Record

15. Birthplace No Record

16. Informant Mrs Gladys Brookman

Address Hagerstown Md.

17. Burial Date thereof 9/19/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Sept. 18, 47 19 47  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 16 19 47 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 19 46 to Sept 19 47

and that I last saw him alive on Sept 16 19 47

Immediate cause of death myocardial failure

Due to arteriosclerosis

Due to

Other condition Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. h. Campbell

Address Hagerstown Md Date signed 9/17/47

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SEP 20 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Wells

Reg. Dist. No. 0830602

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 mins.  
 Hospital, institution, or street address where death occurred:  
West Wash. St., Leiter Bros. Store  
 How long in hospital or institution? none

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Kemps Mill Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War # 1

## 3. (a) FULL NAME

William Allison Burkholder

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Elizabeth

7. Birth date of deceased (mo., day, yr.) October 2 1894

8. AGE: Years 52 Months 11 Days 0 If less than one day hrs. min.

9. Birthplace Scotland, Franklin Cty., Pa.  
 (Town, county, and state)

10. Usual occupation Machinist

11. Industry or business W. M. Rwy. Co.

12. Name William Allison Burkholder

13. Birthplace Scotland, Franklin Cty., Pa.

14. Maiden name Emma Lightner

15. Birthplace Chambersburg, Franklin Cty., Pa.

16. Informant William A. Burkholder, Jr.

Address Hagerstown, Md.

17. Burial Burial Date thereof 9/5/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory National Cemetery, Hagerstown

Location Sharpsburg, Md. Hagerstown

18. Funeral director Andrew K. Coffman

Address Hagerstown, Md.

19. Sept. 4. 47 Registrar

(Date rec'd by registrar)

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

ED 7

20. DATE OF DEATH Sept 2, 47 at 11:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death coronary occlusion DURATION 48hrs.

Due to acute ventricular fibrillation

Due to coronary occlusion

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury None Injured at work?

DEPUTY MEDICAL EXAM. W. M. Rwy. Co., Md.

23. SIGNATURE Robert Wells M. D. None

Address Hagerstown, Md. Date signed 9/3/47

RECEIVED

SEP 6 1947

BUREAU • B

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

08307

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

## 1. PLACE OF DEATH:

County WashingtonCity or town San Mar  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

Johnny Memorial HomeHow long in hospital or institution? 4 years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2.(a) If veteran, name war no ✓

## 3. (a) FULL NAME

Annie L. Cole

## 3. (b) Social Security Number

none4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife John B. Cole

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) January 29 - 18648. AGE: Years 83 Months 7 Days 15 hrs. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Auburn Alabama  
(Town, county, and state)10. Usual occupation none

11. Industry or business \_\_\_\_\_

12. Name Dr. Wm H. La Mar13. Birthplace Augusta Georgia14. Maiden name Annie Glenn15. Birthplace Marietta Georgia16. Informant Mrs. Blanche Lamar SandersAddress 828 - 18th St. N.W. Wash. D.C.17. Burial Date thereof Sept. 17, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Auburn CemeteryLocation Auburn Alabama18. Funeral director Chas E. Bast & SonsAddress Bonnsboro Md.19. Sept. 15, 1947 John A. Bast  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 14, 1947 at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 2, 1947 to Sept 14, 1947and that I last saw him alive on Sept 13, 1947

Immediate cause of death \_\_\_\_\_

Chronic Myocarditis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Mens of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE G. W. Lehan M.D.Address Bonnsboro Date signed 9/15/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 48a  
CERTIFICATE OF DEATH

08308

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
City or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
111 1/2 West Franklin St.  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... Maryland County... Washington  
City or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 111 1/2 West Franklin St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

## 3. (a) FULL NAME

Lula M. Colliflower

## 3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 8.(a) Single, married, widowed, or divorced Married  
8.(b) Name of husband or wife Albert Ross Colliflower  
8.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) May 7, 1886  
8. AGE: Years 61 Months 4 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Welch Run, Penna.  
(Town, county, and state)  
10. Usual occupation Home Duties  
11. Industry or business  
12. Name John C. Rummel  
13. Birthplace Welch Run, Penna.  
14. Maiden name Mary R. Cole  
15. Birthplace Welch Run, Penna.

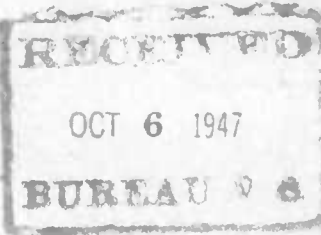
16. Informant Albert Ross Colliflower  
Address 111 1/2 West Franklin St. Hag.  
17. Burial Date thereof Oct. 3, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Rest Haven Cemetery  
Location Hagerstown, Maryland  
18. Funeral director Fred W. Kraiss  
Address Hagerstown, Maryland  
19. Oct. 3, 1947  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1947 2:45 P.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 July 1947, to 30 Sept 1947, and that I last saw h. alive on 30 Sept 1947.  
Immediate cause of death Cerebral hemorrhage DURATION 2 days  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Carcinoma of cervix 6 years  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underlie the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Eldon G. H. Oachlunck M.D.  
M. D. or other \_\_\_\_\_  
Address Hagerstown Md. Date signed 1 Oct 47



Birth and Death  
159

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF STILLBIRTH**

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

**1. PLACE OF BIRTH:**

County Washington  
City or town Hagerstown, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street address, hospital, or institution:  
Washington County Hospital  
Length of mother's stay in County 22 1/2 years  
(How many years, or months, or days. SPECIFY WHICH)

**2. USUAL RESIDENCE OF MOTHER:**

State Maryland  
County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 210 N. Locust Street  
(If RURAL give LOCATION)

**3. Name of child** Baby Girl Cramer

**5. Sex** female **6. Twin or triplet** \_\_\_\_\_

**4. Date of birth** September 24 1947 **Hour** 6:20 A.M.

**7. No. of weeks pregnancy** 26 weeks

**FATHER OF CHILD**

**8. Full name** Howard Ray Cramer

**9. Color** white **10. Age at time of this birth** 33 yrs.

**11. Usual occupation** Mechanic - Blue Ridge Twp.

**MOTHER OF CHILD**

**12. Full maiden name** Ether Pauline Kramer

**13. Color** white **14. Age at time of this birth** 29 yrs.

**15. Usual occupation** housewife

**16. Other children born to mother (not including present child):** (a) How many children of this mother are now living? 0  
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 1

**17. Did child die before labor?** \_\_\_\_\_ **During labor?** \_\_\_\_\_

**18. Pregnancy, complications of** \_\_\_\_\_

**19. Labor:** (a) Complications of \_\_\_\_\_ (b) Induced? \_\_\_\_\_

**20. (a) Was there an operation for delivery?** \_\_\_\_\_ (Yes or No)

(b) State all operations, if any \_\_\_\_\_

(c) Did child die before operation? \_\_\_\_\_  
During operation? \_\_\_\_\_

**21. Cause of stillbirth.** Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes prematurity

(b) Maternal causes \_\_\_\_\_

**22. I certify to the birth of this child who was born dead\* on the date and hour above stated.**

**Signature** Stefanescu MD  
(Specify if M. D., midwife, or other)

**Address** Hagerstown, Md.

**23. (a)** Burial (b) Date thereof 9-24-47  
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Lutheran Cemetery

**24. (a) Funeral director** Sec. F. Minnich

(b) Address Hagerstown Md.

**25. (a)** \_\_\_\_\_ (b) \_\_\_\_\_  
(Date rec'd by registrar) (Registrar)

**26. (To be filled out if no physician was present at delivery.)**  
The above certificate has been examined by me.

Health Officer, per \_\_\_\_\_

\* See Instruction C on stub.

Child lived 2 hrs and 47 min.

V. S. A10

RECEIVED  
SEP 26 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08310

Reg. Dist. No. 305

## 1. PLACE OF DEATH:

County Washington  
 City or town Mapleville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death Life  
 Hospital, institution, or street address where death occurred:  
Main St.  
 How long in hospital or institution? at Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Mapleville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Main St.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war no.

## 3. (a) FULL NAME

Gertrude Anna Florence Cunningham

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife William Cunningham  
 6. (c) If alive, give age 20 years  
 7. Birth date of deceased (mo., day, yr.) June - 19 - 1879  
 8. AGE: Years 68 Months 2 Days 20 If less than one day hrs. min.

9. Birthplace near Boonsboro Wash. Co. Md.  
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business Open Home

12. Name John Smith

13. Birthplace Ired. Co. Md.

14. Maiden name Maryella Smith

15. Birthplace Ired. Co. Md.

16. Informant Mrs. Elmer Gross

Address Mapleville Md.

17. Burial Date thereof Sept. 12, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Farmers Cemetery

Location near Mapleville Md.

18. Funeral director Wm. J. Best & Sons

Address Boonsboro Md.

19. Sept. 12, 1947 John H. Best  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 9, 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30, 1945 to Sept. 19, 47  
 and that I last saw him alive on Sept. 6, 1947

Immediate cause of death Complication of Bronch.  
Arterial Hypertension

Due to Arterial Hypertension

Due to Arterial Hypertension

Due to Arterial Hypertension

Other conditions Arterial Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations Arterial Hypertension

Date of op. Sept. 12, 1947

Autopsy results Arterial Hypertension

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Arterial Hypertension Date of Sept. 9, 1947

Where did injury occur? Arterial Hypertension (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Arterial Hypertension

Means of injury Arterial Hypertension Injured at work?

23. SIGNATURE John H. Best M. D. or other

Address Boonsboro Md. Date signed 9/10/47

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SEP 16 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

486 X 08311  
Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington  
City or town Rural Hagerstown, Md. R D 4  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 12 years  
Hospital, institution, or street address where death occurred:  
Cearfoss Dist.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Rural Hagerstown R D 4  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Cearfoss Dist.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Lilly May Ditto

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Milton O. Ditto  
7. Birth date of deceased (mo., day, yr.) Aug. 29, 1866 6.(c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 81 Months 0 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington County, Md.  
(Town, county, and state)  
10. Usual occupation Home Duties  
11. Industry or business

MOTHER FATHER  
12. Name David Pittinger  
13. Birthplace Wash. Co., Md.  
14. Maiden name Mary Spickler  
15. Birthplace Wash. Co., Md.

16. Informant Mrs. Harry Pittinger  
Address Hagerstown, Md. R D 4

17. Burial Sept. 7, 1947  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
Cemetery or crematory St. Paul's Cemetery  
Location Near Hagerstown Route 40 W

18. Funeral director Fred W. Kraiss  
Address Hagerstown, Md.

19. Sept. 7, 47 G. East Bowers  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept. 4, 1947 19. 7:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/1 1945 to 9/4 1947  
and that I last saw him alive on 8/30 1947

Immediate cause of death Cerebral infarct  
DURATION 1 yr.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)  
Major findings of operations none  
Date of op. \_\_\_\_\_  
Autopsy results none  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE [Signature] M. D. or other \_\_\_\_\_  
Address [Signature] Date signed 9/6/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 9 1947

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08312

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 years  
 Hospital, institution, or street address where death occurred:  
49 Summit Avenue  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 49 Summit Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... World War 11

## 3. (a) FULL NAME

John D. Fleming

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife  
 6.(c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) October 18, 1910  
 8. AGE: Years 36 Months 11 Days 17 It less than one day  
 hrs. min.

9. Birthplace... Harrisburg, Pa.  
(Town, county, and state)10. Usual occupation... Laborer

11. Industry or business

12. Name... Grant Fleming13. Birthplace... Gettysburg, Pa.14. Maiden name... Mabel J. Baxter15. Birthplace... Harrisburg, Pa.16. Informant... Melvin FlemingAddress... Hagerstown, Maryland17. Burial Date thereof 9-6-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Rest Haven CemeteryLocation... Hagerstown, Maryland18. Funeral director... C. M. Suter & SonsAddress... Hagerstown, Maryland19. Sept. 6, 1947 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept. 4, 1947 at 9:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h... alive on 19...

Immediate cause of death... Acute coronary occlusion DURATION 15 hrs.

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... None

Date of op...

Autopsy results... As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... No Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Robert M. Wells DEPUTY MEDICAL EXAM.Address... Hagerstown, Md. WASH. CO., MD.Date signed... 9/5/47

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SEP 9 1947

BUREAU

PRC

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

08313

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... WashingtonCity or town..... Hagersown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 16 hoursHospital, institution, or street address where death occurred:  
Wash. Co. Hosp.How long in hospital or institution?..... 16 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... WashingtonCity or town..... Hancock  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (a) FULL NAME

Martha Irene Francis

## 3. (b) Social Security Number

4. Sex..... female5. Color or race..... white6. (a) Single, married, widowed, or divorced..... single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... Sept. 11, 19478. AGE: Years..... Months..... Days..... If less than one day.....  
16 hrs. .... min.9. Birthplace..... Maryland  
(City, town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... Russell Francis

13. Birthplace.....

MOTHER 14. Maiden name..... Ethel Miller

15. Birthplace.....

16. Informant.....  
Address.....17. Burial Date thereof..... 9/16/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Mays Chapel CemeteryLocation..... Snyder and Rowland18. Funeral director..... Hancock, Maryland

Address.....

19. ....19.....  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 17 19..... 47, at..... 1 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
11 Sept. 19..... 47, to..... 12 Sept. 19..... 47,  
and that I last saw him alive on..... 12 Sept. 19..... 47.Immediate cause of death..... 2. tuberculosisDue to..... 1. pneumonia

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Edm. J. H. ...  
\*\* Signature of physician M. D. or otherAddress..... Date signed..... 11 Oct. 47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08214

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 336 Mitchell Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Edgar Lewis Golden

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1947

## 8. AGE:

Years

Months

Days

If less than one day

----1

hrs.

min.

9. Birthplace Hagerstown-Washington-Md.  
(Town, county, and state)10. Usual occupation None- Infant

## 11. Industry or business

12. Name John Richard Golden13. Birthplace Wash. Co. Md.14. Maiden name Ethel L. Golden15. Birthplace Washington County, Md.16. Informant Ethel L. GoldenAddress 336 Mitchell Ave- Hagerstown, Md.17. Burial Date thereof Sept. 20-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fahrney's CemeteryLocation Mapleville, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. Sept. 20, 1947 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1947 3:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

DURATION

Due to Atelectasis

(Premature birth 7 Mo.)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

no Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Robert Wells, M.D. M. D. or otherAddress Hagerstown, Md. Date signed 9/20/47

RECEIVED

SEP 23 1947

BUREAU

8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 83a 08315 304

1. PLACE OF DEATH:  
 County... Washington  
 City or town... Pectonville, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Five months  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State... Maryland County... Washington  
 City or town... Pectonville, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Lucinda Graham

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife Thomas Graham  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) February 4, 1871  
 8. AGE: Years 76 Months 7 Days 26 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington Co., Md.  
 (Town, county, and state)  
Home duties  
 10. Usual occupation  
 11. Industry or business  
 12. Name Samuel Hastings  
 13. Birthplace Wash. Co. Md.  
 14. Maiden name Jennie Bridendolph  
 15. Birthplace Wash. Co. Md.

16. Informant Miss Minerva Hastings  
 Address Pectonville, Md.  
 17. Burial Date thereof Oct. 3, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Cemetery  
 Location Mercersburg, Pa.  
 18. Funeral director Snyder-Rowland  
 Address Hancock, Md.  
 19. 10-2-47 19 \_\_\_\_\_  
 (Date rec'd by registrar) Registrar J. M. Heller

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1947 at 10:30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1944 to Sept. 30, 1947  
 and that I last saw him alive on Sept. 23, 1947  
 Immediate cause of death

Cerebral Hemorrhage Sudden  
 Due to Arterial Sclerosis 8 yrs.  
 Due to Arterial Hypertension  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE David P. Brewer M.D. M. D. or other  
 Address Clear Spring Md. Date signed 10/1/47

RECEIVED

OCT 4 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Ditto

08316

131a

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 Days  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 6 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Clearspring R#1  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. St. Pauls  
 (If rural, give LOCATION) A.S.N. 24334  
 2. (a) If veteran, name war... Spanish American War

## 3. (a) FULL NAME

HARRY HAMBY SR.

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Susie Bingham Hamby  
 7. Birth date of deceased (mo., day, yr.) November 14, 1881  
 8. AGE: Years 65 Months 9 Days 29 It less than one day hrs. min.  
 5. (c) If alive, give age 63 years

9. Birthplace Chewsville, Washington Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business Retired

12. Name James M. Hamby  
 13. Birthplace Chewsville Md.  
 14. Maiden name Mary Robison  
 15. Birthplace Chewsville Md.

16. Informant Mrs. Susie B. Hamby  
 Address Hagerstown R#3 Md.

17. Burial Date thereof 9/16/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Dunkard Cemetery  
 Location Broadfording Md.

18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. Sept. 16, 47 Charles Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 13, 1947 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 6-47 19 Sept 13-47  
 and that I last saw him alive on Sept 12-47 19

Immediate cause of death

DURATION

Ch. Myocarditis 1 year  
 Due to Tricuspid Stenosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

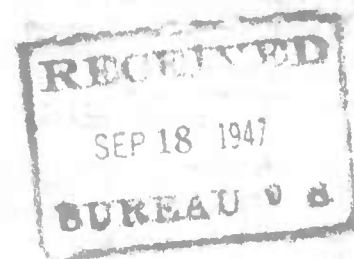
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. D. Smith M. D. or otherAddress Hagerstown Md. Date signed Sept 16, 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08317

58

Reg. Dist. No.

304

## 1. PLACE OF DEATH:

County WashingtonCity or town Hancock  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

## 3. (a) FULL NAME

Charles Edgar Henry

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Burgess Henry

7. Birth date of

deceased (mo., day, yr.) Aug. 31, 1881

8. AGE:

Years

Months

Days

If less than one day

66023

hrs.

min.

9. Birthplace

Hancock Wash. Co., Md.  
(Town, county, and state)

10. Usual occupation

B+O. Telegraph Operator

11. Industry or business

MOTHER FATHER

12. Name

Charles David Henry

13. Birthplace

Morgan Co., W. Va.

14. Maiden name

Mary Elizabeth Michael

15. Birthplace

Morgan Co., W. Va.

16. Informant

John Henry

Address

3011 Kittittia Ave., Balto., Md.

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

Sept. 26, 1947  
(Month) (day) (year)

Cemetery or crematory

St. Thomas Episcopal

Location

Hancock, Md.

18. Funeral director

Charles R. Bast

Address

Hancock, Md.

19.

9/26-47  
(Date rec'd by registrar)J. H. Heller  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock  
(If outside city or town limits, write RURAL and give nearest town)Street No. East Main St.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

705-05-8020

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1947 at 2 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Sept 23, 1947

Immediate cause of death

Cardiac Block

DURATION

Immediate

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Heller

M. D. or other

Address

Hancock Md

Date signed

9/26/47

RECEIVED

SEP 29 1947

BUREAU # 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1310

08318

303

## 1. PLACE OF DEATH:

County Washington  
 City or town near Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 days  
 Hospital, institution, or street address where death occurred:  
Gate Way Nursing Home  
 How long in hospital or institution? 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Pa County Franklin  
 City or town Greencastle Pa  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 414 E. Baltimore St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

EMMA MYERS HOFFMAN

## 3. (b) Social Security Number

None

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Emanuel H. Myers  
 6. (c) If alive, give age decd years  
 7. Birth date of deceased (mo., day, yr.) Oct. 12, 1863  
 8. AGE: Years 83 Months 10 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Wish Run Pa  
 (Town, county, and state)  
 10. Usual occupation House Keeper  
 11. Industry or business Home

MOTHER FATHER  
 12. Name John Myers  
 13. Birthplace Penn  
 14. Maiden name Maria Hawbaker  
 15. Birthplace Pa  
 16. Informant Charles W. Hoffman  
 Address Greencastle Pa  
 17. (Burial, cremation, or removal) Which? B Date thereof Sept 5/47  
 (Monthly day) (year)  
 Cemetery or crematory Bur View  
 Location Williamsport Md  
 18. Funeral director C.E. Munnich  
 Address Greencastle Pa

19. Sept 3 19 47  
 (Date rec'd by registrar) Registrar W. L. Lollar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2<sup>nd</sup> 1947 at 3:45 PM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/11 19 46 to 9/12 19 47  
 and that I last saw him ex alive on 9/11 19 47  
 Immediate cause of death arteriosclerotic  
Cardio-vascular-renal disease DURATION 15 yrs.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)  
 Major findings of operations None done Date of op. \_\_\_\_\_  
 Autopsy results No autopsy  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. L. Lollar M. D. or other \_\_\_\_\_  
 Address Greencastle, Pa. Date signed 9/5/47

ARTISTIAN LEON  
AND CONTENT

RECEIVED  
SEP 19 1947  
BUREAU 'C' 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Ditto

C8319

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
12 Hours  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 135 McComas St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

Raymond Wingert Hoover

## 3. (b) Social Security Number

214-09-2403

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Lottie May Hoover

7. Birth date of deceased (mo., day, yr.) August 9, 1891  
 8.(c) If alive, give age 51 years

8. AGE: Years 56 Months 1 Days 19 If less than one day  
 hrs. min.

9. Birthplace Mowersville, Cumberland Co., Pa.  
(Town, county, and state)10. Usual occupation Machinist11. Industry or business Brandt Cabinet works12. Name Samuel Hoover13. Birthplace Mowersville Pa.14. Maiden name Barbara Bricker15. Birthplace Mowersville Pa.16. Informant Mrs. Lottie May HooverAddress Hagerstown Md.

17. Burial Date thereof 9/30/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Hill CemeteryLocation Shippensburg Pa.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.

19. Sept. 29, 1947 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1947 at 4:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 - 86, to Sept 28, 47  
 and that I last saw him alive on Sept 27-47 1947

Immediate cause of death

DURATION

Cerebral Liver 6 yrs  
Chr. Nephritis 1 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. D. Ditto M. D. or other

Hagerstown Md. Date signed 9/29/47  
 Address

RECEIVED  
OCT 1 1947  
BUREAU 48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08320

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County..... Washington.....  
 City or town..... Hagerstown.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 50 years.....  
 Hospital, institution, or street address where death occurred:  
515 Brown Avenue  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland..... County..... Washington.....  
 City or town..... Hagerstown.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 515 Brown Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Lydia Ann Huyett

3. (b) Social Security Number  
None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife Huron A. Huyett

## 7. Birth date of

deceased (mo., day, yr.)

March 26, 1851

## 6. (c) If alive, give age..... years

## 8. AGE:

Years 96Months 5Days 15

If less than one day

hrs.

min.

9. Birthplace..... Washington County, Md.  
(Town, county, and state)10. Usual occupation..... Home Duties

## 11. Industry or business

MOTHER FATHER

12. Name..... Abram Shupp13. Birthplace..... Wash. Co., Md.14. Maiden name..... Ann Smith15. Birthplace..... Wash. Co. Md.16. Informant..... Eva L. HuyettAddress..... 515 Brown Ave- Hagerstown, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Sept. 13-47

(month) (day) (year)

Cemetery or crematory..... Rose Hill CemeteryLocation..... Hagerstown, Md.18. Funeral director..... Fred W. KraissAddress..... Hagerstown, Md.19. Sept. 12. 47  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 10, 1947 11:55 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-1-45 to 9-10-47and that I last saw her alive on 9-5-47

Immediate cause of death.....

DURATION

Due to..... SenilityDue to..... Chc. Myocarditis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... [Signature]

M. D. or other

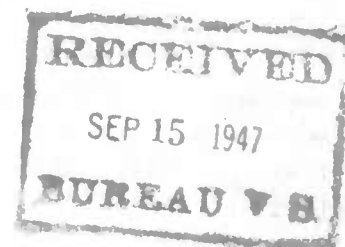
Address..... Hagerstown, Md. Date signed..... 9/16/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The form at age is especially important. Physicians: please write the causes of death clearly and legibly.



08321

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington  
 County.....  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 years  
 Hospital, institution, or street address where death occurred:  
 Washington County Hospital  
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Md. County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 551 Jefferson St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

## 3. (a) FULL NAME

Nellie L. Kline

## 3. (b) Social Security Number

-

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Scott M. Kline  
 6. (c) If alive, give age 46 years  
 7. Birth date of deceased (mo., day, yr.) February 16, 1912  
 8. AGE: Years 35 Months 6 Days 18 If less than one day  
 hrs. min.

9. Birthplace Hagerstown, Wash. Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Weaver  
 11. Industry or business Cromer's Silk Mill  
 12. Name Harvey L. Smith  
 13. Birthplace Hagerstown, Md.  
 14. Maiden name Minnie Mae Strock  
 15. Birthplace Hagerstown, Md.  
 16. Informant Scott M. Kline, Jr.  
 Address Hagerstown, Md.

17. Burial Date thereof Sept. 17, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Md.  
 18. Funeral director Scott F. Minnich & Son  
 Address Hagerstown, Md.  
 19. Sept. 16, 1947 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1947 at 7:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 Aug 30 1947 to Sept 14 1947  
 and that I last saw him alive on Sept 14 1947

Immediate cause of death UNDETERMINED

Due to ACUTE FERRILE  
 ILLNESS OF UNKNOWN CAUSE

Other conditions 2. BRONCHIAL PNEUMONIA 2 DAYS  
 3. PSYCHOSIS 6 WRS  
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results BRONCHIAL PNEUMONIA LEFT  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

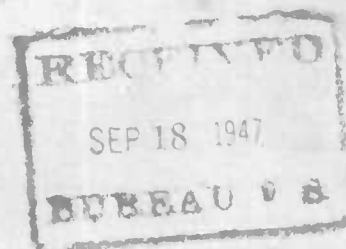
23. SIGNATURE M. J. Lyman, M.D.  
 Address 100 Pruden Ave Bldg M. D. or other  
 Date signed Sept 15, 1947

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

08322<sup>237</sup>

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... City or town..... Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME TRUMAN S. KUHN				3. (b) Social Security Number none			
4. Sex M. W.		5. Color or race Widowed		8. (a) Single, married, widowed, or divorced			
6. (b) Name of husband or wife Emma M. Kuhn				6. (c) If alive, give age..... years			
7. Birth date of deceased (mo., day, yr.) MAR 25, 1868							
8. AGE: Years 79		Months 5		Days 15		If less than one day hrs. min.	
9. Birthplace St Thomas Pa (Town, county, and state)							
10. Usual occupation Farmer							
11. Industry or business Retired							
12. Name Jacob B. Kuhn		13. Birthplace Penna					
14. Maiden name Kathryn Leites		15. Birthplace Penna					
16. Informant Leo Kuhn Address Kauffman Station Pa B							
17. (Burial, cremation, or removal, Which) Salem Cemetery near Marion Pa A.E. Munnich Address Greencastle Pa Sept. 12, 1947 (Date rec'd by registrar)				Date thereof Sept 13/47 (month) (day) (year) Registrar			
19. (Date rec'd by registrar)				20. DATE OF DEATH Sept 10 1947, at 5:30			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from and that I last saw him alive on Immediate cause of death Due to Due to Other conditions (Include pregnancy within 3 months of death) Major findings of operations Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Where did injury occur? Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Address Date signed				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from and that I last saw him alive on Immediate cause of death Due to Due to Other conditions (Include pregnancy within 3 months of death) Major findings of operations Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Where did injury occur? Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Address Date signed			

RECEIVED

SEP 15 1947

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Yeager

08323

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 Weeks  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 3 Weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1249 Potluc Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

DR. AUGUSTUS CARL MAISCH

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Elda T.6. (c) If alive, give age 71 years7. Birth date of deceased (mo., day, yr.) July 1, 1872

## 8. AGE:

Years

Months

Days

It less than one day

75

2

27

hrs.

min.

9. Birthplace Philadelphia, Philadelphia Co., Pa.  
(Town, county, and state)10. Usual occupation Doctor11. Industry or business Oculist12. Name John M. Maisch13. Birthplace Germany14. Maiden name Charlotte J. Kuhl15. Birthplace Germany18. Informant Mrs Elda T. MaischAddress Hagerstown Md17. Burial Date thereof 9/30/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Sept. 29, 47 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 28, 1947 at 5 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 22, 1947 to Sept. 28, 1947 and that I last saw him alive on Sept. 28, 1947

Immediate cause of death

Cerebral Vascular DiseaseChronic Pul Tuberculosis

DURATION

5 yrs.

Due to

27 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X X X Date of XWhere did injury occur? X X X  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. Howard YeagerAddress Hagerstown, Md M. D. Sept. 29, 1947  
Date signed

RECEIVED

OCT 1 1947

BUREAU

RECEIVED

OCT 1 1947

240 \* 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:  
 County.....Washington  
 City or town.....Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....Died enroute to hospital  
 Hospital, institution, or street address where death occurred:  
Virginia Avenue  
 How long in hospital or institution?.....Dead on admittance

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....Maryland County.....Washington  
 City or town.....Williamsport (RURAL)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....Greencastle Pike  
 (If rural, give LOCATION)  
 2.(a) If veteran, name War.....

3. (a) FULL NAME  
David Thomas Ilesher Malott

3. (b) Social Security Number  
None

4. Sex.....Male 5. Color or race.....White 6. (a) Single, married, widowed, or divorced.....Married  
 6. (b) Name of husband or wife.....Emma Virginia Malott  
 6. (c) If alive, give age.....47 years  
 7. Birth date of deceased (mo., day, yr.).....Nov. 23, 1894  
 8. AGE: Years.....52 Months.....9 Days.....12 It less than one day.....hrs......min.

9. Birthplace.....Williamsport, Washington, Maryland  
 (Town, county, and state)

10. Usual occupation.....Truck operator  
 11. Industry or business.....Hauling and Transfer & Ice

FATHER 12. Name.....James Elias Malott  
 13. Birthplace.....Williamsport, Maryland  
 MOTHER 14. Maiden name.....Emma Maddox Knodle  
 15. Birthplace.....Near Tilghmanton, Maryland

16. Informant.....Mrs. Emma V. Malott  
 Address.....Route # 1 Williamsport, Maryland

17. Burial Date thereof.....Sept. 7, 1947  
 (Burial, cremation, or removal. Which?).....(month) (day) (year)  
 Cemetery or crematory.....Greenlawn Cemetery  
 Location.....Williamsport, Maryland  
 18. Funeral director.....Mrs. Edith V. Leaf

Address.....Williamsport, Maryland.  
 19. Sept. 6, 1947 Registrar  
 (Date rec'd by registrar)

MEDICAL CERTIFICATION D.S.T.  
 20. DATE OF DEATH.....SEPTEMBER 5, 1947 at 8:00 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
February 2, 1946 to SEPT. 5, 1947  
 and that I last saw him alive on JULY 18, 1947

Immediate cause of death.....CORONARY OCCLUSION  
 DURATION.....1 min.

Due to.....CHRONIC MYOCARDITIS?

Due to.....

Other conditions.....None.

(Include pregnancy within 3 months of death)

Major findings of operations.....None.

Autopsy results.....None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....Archie Robert Cohen  
 M. D. Clear Spring Md

Address..... Date signed.....9-5-47

RECEIVED

SEP 9 1947

BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08325

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 years  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? One day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 120 East Antietam Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Maude A. McCoy

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Merritt M. McCoy  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 17, 1881  
 8. AGE: Years 66 Months 4 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bedford, Pa.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business

FATHER 12. Name Not Known  
 13. Birthplace  
 MOTHER 14. Maiden name Not Known  
 15. Birthplace

16. Informant Mrs. Daniel Meyers  
 Address Hagerstown, Maryland  
 17. Burial Date thereof 10-2-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rest Haven Cemetery  
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland

19. Oct 1, 47 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29, 1947 at 4:20 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to Sept 29, 1947  
 and that I last saw her alive on Sept 29, 1947

Immediate cause of death Heart block -  
 Due to Arteriosclerosis Heart Disease 4 yrs?  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Harold Phibbs M. D. or other  
 Address Hagerstown Md. Date signed 10/1/47

RECEIVED

OCT 3 1947

BURTON

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

08326

Reg. Dist. No. 207

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Rural Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months  
 Hospital, institution, or street address where death occurred:  
 Wilsons Route 40 W  
 How long in hospital or institution? 3 Months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 311 Summit Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Temma Moser

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow

## 6. (b) Name of husband or wife

Elmer C. Moser

## 7. Birth date of deceased (mo., day, yr.)

October 3, 1867

## 6. (c) If alive, give age years

## 8. AGE:

79

11

18

If less than one day

hrs. min.

## 9. Birthplace

Myersville - Fredk. Co., Md.  
(Town, county, and state)

## 10. Usual occupation

Home Duties

## 11. Industry or business

FATHER  
MOTHER

12. Name... Aaron Poffenberger

13. Birthplace... Frederick Co., Md.

14. Maiden name... Caroline Marteny

15. Birthplace... Frederick, County, Md.

## 16. Informant

Mrs. C. Ray Ford,

Address 311 Summit Ave. Hagerstown, Md.

## 17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof Sept. 24, 1947  
(month) (day) (year)

Cemetery or crematory... Rest Haven

Location... Hagerstown, Md.

## 18. Funeral director

Fred W. Kraiss

Address Hagerstown, Md.

19

Sept 23, 1947  
(Date rec'd by registrar)R. M. Zacher  
Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1947 7:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 - 49, to Sept 20 - 47  
and that I last saw him alive on Sept 20 - 47

Immediate cause of death

Coronary - Venous Disease

DURATION

6 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Date signed

RECEIVED

NOV 5 1947

BUREAU 9

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

159 08327

Reg. Diat. No. 302

## 1. PLACE OF DEATH:

County... WASHINGTON  
 City or town... HAGERSTOWN  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... LIFE  
 Hospital, institution, or street address where death occurred:  
WASHINGTON COUNTY HOSPITAL  
 How long in hospital or institution?... 12 HRS.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... MARYLAND County... WASHINGTON  
 City or town... RURAL - LEITERSBURG  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... HAGERSTOWN R.F.D. #5  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

BABY GIRL MYERS

## 3. (b) Social Security Number

NONE

4. Sex... FEMALE 5. Color or race... WHITE 6.(a) Single, married, widowed, or divorced... SINGLE  
 6.(b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.)... SEPTEMBER 7, 1947  
 8. AGE: Years Months Days If less than one day  
12 hrs. min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 7 Sept 19 47 at 9:50 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
7 Sept 19 47, to 7 Sept 19 47  
 and that I last saw h. or alive on 19.....  
 Immediate cause of death... Prematurity  
(15 mo)  
 DURATION  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

9. Birthplace... HAGERSTOWN, WASHINGTON, MD.  
 (Town, county, and state)  
 10. Usual occupation.....  
 11. Industry or business.....  
 12. Name... CHARLES V. MYERS JR.  
 13. Birthplace... HAGERSTOWN, R.F.D.#5, MD.  
 14. Maiden name... KATHLEEN SPRANKLE  
 15. Birthplace... WAYNESBORO, PA.  
 16. Informant... Charles V. Myers  
 Address... Hagerstown R.F.D.#5  
 17. BURIAL Date thereof... 9/9/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... LUTHERN CHURCH CEM.  
 Location... LEITERSBURG, MD.  
 18. Funeral director... W. T. NORMENT  
 Address... HAGERSTOWN, MD.  
 19. Sept. 9, 47 Registrar  
 (Date rec'd by registrar)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?  
 23. SIGNATURE... J. J. Lusby M. D. or other  
 Address... 230 N Potomac Date signed... 9 Sept 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and fully.

RECEIVED  
SEP 11 1947  
BUREAU T. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

08328

82

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Two weeksHospital, institution, or street address where death occurred:  
Washington County HospitalHow long in hospital or institution? Two weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 42 West Salisbury Street(If rural, give LOCATION)  
None

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles Thomas Palmer

## 3. (b) Social Security Number

219-05-2199

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Anna Belle Palmer: 6. (c) If alive, give age 70 yrs. years7. Birth date of deceased (mo., day, yr.) Feb. 22, 1884

8. AGE: Years Months Days If less than one day

63619

.....hrs. ....min.

9. Birthplace Williamsport, Washington, Maryland

(Town, county, and state)

10. Usual occupation Leather FinisherLeather Tannery

11. Industry or business

FATHER 12. Name Nathan Palmer13. Birthplace VirginiaMOTHER 14. Maiden name Frances Elizabeth Howard15. Birthplace Near Williamsport, Maryland16. Informant Anna Belle PalmerAddress Williamsport, Maryland17. Burial Date thereof Sept. 14, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Riverview CemeteryLocation Williamsport, Maryland18. Funeral director Mrs. Edith V. LeafAddress Williamsport, Maryland19. Sept. 14, 1947 W. Bowers

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1947, at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 28 1947 to Sept. 11 1947and that I last saw him alive on Sept. 11 1947

Immediate cause of death

Influenza myelitis

## DURATION

14 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE W. Bowers

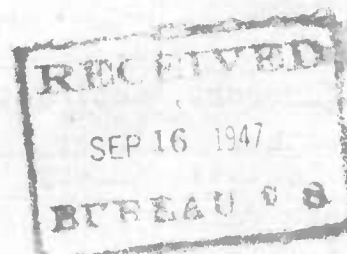
M. D. or other

Address Williamsport, Md.Date signed 9/13/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08329

Reg. Dist. No.

307

## 1. PLACE OF DEATH:

County WashingtonCity or town Trego  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Trego  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Elizabeth Pike

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife Edgar B. Pike7. Birth date of deceased (mo., day, yr.) Feby. 21, 1880  
6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 67 Months 7 Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Washington County, Md.  
(Town, county, and state)10. Usual occupation Home Duties

11. Industry or business \_\_\_\_\_

12. Name Daniel Drury13. Birthplace Franklin Co., Pa.14. Maiden name Susan H. Wilson15. Birthplace Franklin Co., Pa.16. Informant Mrs. Merle ClippAddress Trego, Md.17. Burial Date thereof Sept. 25, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Broadfording CemeteryLocation Near Cearfoss, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. Sept. 25 19 47 Mrs. Katherine Degenhart  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1947 3:50 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7, 19 47 to Sept. 22, 19 47and that I last saw her alive on September 21, 19 47Immediate cause of death Broncho-pneumonia DURATION 3 daysDue to Chronic hepatitis and chronic cholangitis 5 years

Due to \_\_\_\_\_

Other conditions Arterio-sclerotic heart disease 5 years.  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

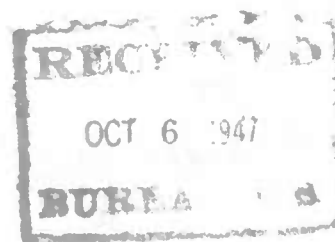
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Henry Aldis M.D. M. D. or other \_\_\_\_\_Address Shepherdstown, W. Va. Date signed 9/24/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

One day  
Hospital, institution, or street address where death occurred:Washington Co. Hospital

How long in hospital or institution?

One day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Pectonville, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. World War Two  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Wallace Wilbur Reed

## 3.(b) Social Security Number

219-12-0873

## 4. Sex

male

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

single

## 6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

## 7. Birth date of deceased (mo., day, yr.)

May 24, 1921

## 8. AGE:

Years

Months

Days

If less than one day

26318

hrs.

min.

## 9. Birthplace

Williamsport, Md.

(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

FATHER

## 12. Name

Daniel Elwood Reed

## 13. Birthplace

Maryland

MOTHER

## 14. Maiden name

Mary M. Mills

## 15. Birthplace

Park Head, Md.

## 16. Informant

Mrs Mary M. Mills

Address

Pectonville, Md.

## 17.

Burial

Date thereof

Sept. 14, 1947  
(month) (day) (year)

Cemetery or crematory

Cemetery

Location

Park Head, Md.Snyder-Rowland

## 18. Funeral director

Address

Hancock, Md.

## 19.

Sept. 13, 47  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Sept. 11, 1947

19.....

at

11:00 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to.....

19.....

and that I last saw him.....

alive on.....

19.....

Immediate cause of death

DURATION

Open fracture of left humerus

Due to

exsanguination & shock

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/11/47Where did injury occur? 6 1/2 mi west Hagerstown, Wash. (County) Md. (State)Injured at home, farm, industry, public place (where) Route # 218 - 6 1/2 mi west HagerstownMeans of injury Auto collided with coal trestle Injured at work? NoDEPUTY MEDICAL EXAM. WASH CO, MDSignature S. R. Wells M. D. WellsAddress Hagerstown, Md Date signed 9/13/47

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08330 302

## 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yearsHospital, institution, or street address where death occurred:  
252 Frederick StreetHow long in hospital or institution? at Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 252 - Frederick Street  
(If rural, give LOCATION)2.(a) If veteran, name war no.

## 3. (a) FULL NAME

Samuel W. Reeder

## 3. (b) Social Security Number

none

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Annie Reeder

## 7. Birth date of deceased (mo., day, yr.)

January - 15 - 1867

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

8080

hrs.

min.

9. Birthplace near Rockville Wash. Co. Md.  
(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

Retired

## FATHER

## 12. Name

Andrew Reeder

## 13. Birthplace

Wash. Co. Md.

## MOTHER

## 14. Maiden name

Ruthette Boyer

## 15. Birthplace

Wash. Co. Md.

## 16. Informant

Mrs. E. C. Hemminger

## Address

252 Frederick St. Hagerstown Md.

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

Sept. 18, 1947  
(month) (day) (year)

## Cemetery or crematory

Locust Grove Cemetery

## Location

Locust Grove Wash. Co. Md.

## 18. Funeral director

Wm. J. Best & Son

## Address

Brownsville Md.

## 19.

Sept. 17, 1947  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH September - 15 - 1947 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12, 1947 to Sept. 15, 1947  
and that I last saw him alive on September 14, 1947

## Immediate cause of death

Coronary Thrombosis of Heart

## DURATION

2 mos.

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

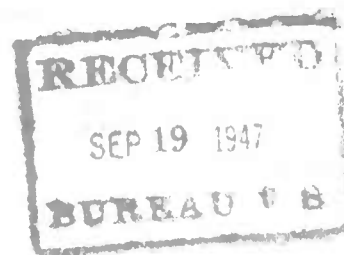
## 23. SIGNATURE

Isabel ReederM. D.

M. D. or other

Address

Brownsville Md.Date signed 9/16/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Wash. Co. Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 113 North Locust St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Fredrick A. Risling

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Ida M. Risling

7. Birth date of deceased (mo., day, yr.)

Sept. 12, 1874

6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

73--

hrs.

min.

9. Birthplace Bedford County, Pa.  
(Town, county, and state)10. Usual occupation Store Employee

## 11. Industry or business

Grocery

## FATHER

12. Name Joseph Risling

## MOTHER

13. Birthplace Bedford Co., Pa.

## 14. Maiden name

Jennie Hoffman

## 15. Birthplace

Bedford Co., Pa.16. Informant Mrs. Baxter NunamakerAddress 113 N. Locust St/ Hagerstown, Md.17. Burial Date thereof Sept. 14, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. Sept. 13, 1947  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1947 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/1/47 to 9/12/47  
and that I last saw him alive on 9/12/47

Immediate cause of death

DURATION

Congestive Heart Failure 1 mo.

Due to

Due to

Other conditions

atherosclerosis left  
myocardial infarction  
(Include pregnancy within 3 months of death)2 mos

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Hagerstown, Md. Date signed 9/13/47

RECEIVED  
SEP 16 1947  
BUREAU 8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08332

## CERTIFICATE OF DEATH

Reg. Dist. No. 363

## 1. PLACE OF DEATH:

County... WashingtonCity or town... Rural - Clearspring  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred:

Gateway Nursing HomeHow long in hospital or institution? 2 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock  
(If outside city or town limits, write RURAL and give nearest town)Street No. Main Street  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Ira G. Robinson

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Mary E. MentzerRobinson6.(c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) April 5, 1878

8. AGE:

Tears

Months

Days

If less than one day

6951— hrs.— min.9. Birthplace Wheatland Mercer, Penna.  
(Town, county, and state)10. Usual occupation Contractor - State Roads Builder

11. Industry or business

FATHER

12. Name

John Robinson

13. Birthplace

Penna.

MOTHER

14. Maiden name

Amanda Gould

15. Birthplace

Penna.16. Informant Mrs. Mary E. Robinson

Address

Hancock, Md.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof Sept 9, 1947  
(month) (day) (year)Cemetery or crematory Geeseytown CemeteryLocation Geeseytown, Blair Co., Penna.

18. Funeral director

Charles R. Bast

Address

Hancock, Md.

19. (Date rec'd by registrar)

Sept 11, 1947 Henry H. Forker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6, 1947 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 5, 1947 to Sept 6, 1947and that I last saw him alive on Sept 5, 1947

Immediate cause of death

Cerebral hemorrhage, right  
c. hemisphereDue to generalized arterio-sclerosis

Due to

Other conditions urinary tract infectionarterio-sclerotic heart disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

R. L. Hauffer, M.D.

M. D. or other

Address Hagerstown, Md. Date signed Sept 6, 1947

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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SEP 19 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

08333

257

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Keedysville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Charlotte G. Rohrer

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 8. AGE: Years 73 Months 10 Days 12 If less than one day  
 7. Birth date of deceased (mo., day, yr.) Nov. 14, 1873 6.(c) If alive, give age ..... years  
 8. AGE: Years 73 Months 10 Days 12 If less than one day  
 ..... hrs. .... min.

9. Birthplace Capland-Washington-Maryland  
 (Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name Daniel C. Grove

13. Birthplace Middletown, Maryland

14. Maiden name Julia Huffer

15. Birthplace Middletown, Maryland

16. Informant Mr. Arthur Rohrer

Address Boonsboro, Md. R. F. D.

17. Burial Date thereof Sept. 28, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rohrersville

Location Rohrersville, Md

18. Funeral director R. I. Earnshaw

Address Keedysville, Md

19. Sept. 27, 1947 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 19 47 at 5:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 19 47 to Sept. 26 19 47  
 and that I last saw him alive on Sept. 24 19 47

Immediate cause of death

Carcinoma of colon

## DURATION

6 min

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. M. D. M. D. or other

Address Boonsboro Date signed 9/27/47

WAS CONTENT

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BUREAU \* 6

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1276

08334

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 years  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 25 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 533 Maryland Avenue  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Jennie Shipley

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife John Shipley

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age years

October 16, 1882  
 8. AGE: Years Months Days If less than one day  
 64 11 hrs. min.

9. Birthplace Shepherdstown, W. Va.  
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name John H. Hill

13. Birthplace Winchester, Virginia

14. Maiden name Martha Hawn

15. Birthplace Winchester, Virginia

16. Informant Mrs. Alma Carroll

Address Hagerstown, Maryland

17. Burial Date thereof 9-18-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. View Cemetery

Location Sharpsburg, Maryland

18. Funeral director C. M. Suter &amp; Sons

Address Hagerstown, Maryland

19. Sept. 17, 1947 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1947 at 4:32 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28, 1947, to Sept. 16, 1947, and that I last saw him alive on Sept. 15, 1947.

Immediate cause of death Cholecystectomy

Due to Pneumonia

Due to Rheumatoid Arthritis

Other conditions Multiple

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Abdominal Wall - Bladder

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Howard J. Jeger

Address Hagerstown, Md.

Date signed 9-16-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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SEP 19 1947  
BUREAU # 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington  
City or town Hagerstown Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 63 years  
Hospital, institution, or street address where death occurred:  
966 Virginia Ave.  
Now long in hospital or institution? \_\_\_\_\_

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 866 Virginia Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

**3. (a) FULL NAME**

Catherine Elizabeth Sierelmann

## 3. (b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	
Female	White	Widow	
6.(b) Name of husband or wife		Conrad A. Siegelinger	
7. Birth date of deceased (mo., day, yr.)		6.(c) If alive, give age	
January 9 - 1852		years	
8. AGE:	Years	Months	Days
95	8	-	If less than one day
		.....hrs: ..... min.	
9. Birthplace: Hesse Darmstadt, Germany			
(Town, county, and state)			
10. Usual occupation: Housework			
11. Industry or business			

## 11. industry or business

12. Name Dippoldson  
13. Birthplace Germ any  
14. Maiden name not known  
15. Birthplace Germ any  
16. Informant Miss Lydia Siepeltner  
Address Hagerstown, Maryland  
17. Burial Date thereof 9-11-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Rose Hill Cemetery  
Location Hagerstown, Maryland  
18. Funeral director C. M. Suter & Sons  
Address Hagerstown, Maryland  
19. Sept 9 19 47 Flora Hovers  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8- 1947 at 1 6 1

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Sept 19 47 to 9/8 19 47  
and that I last saw [redacted] alive on 2/4 19 47

Immediate cause of death.....	DURATION
arterio-sclerotic	?
Chronic Endocarditis	?

Due to.....

Due to.....

Other conditions .....

\*\*\*\*\*  
(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

**PHYSICIAN:** Please underline the cause to which death should be charged statistically.

22. **VIOLENCE:** If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... 20 Date of ..... 11/11/1998

Where did injury occur? .....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury	Injured at work?
-----------------	------------------

23. SIGNATURE.....

181 W WASHINGTON ST

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. \_\_\_\_\_

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SEP 11 1947  
BUREAU OF

19

Birch and Death 1572 JB

Reg. Dist. No. 302

08336

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF STILLBIRTH**

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

**1. PLACE OF BIRTH:**

County Washington  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street address, hospital, or institution:  
Washington County Hospital  
 Length of mother's stay in County 1 day  
 (How many years, or months, or days. SPECIFY WHICH)

**2. USUAL RESIDENCE OF MOTHER:**

State Pennsylvania  
 County Franklin  
 City or town Greencastle  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rural #3  
 (If RURAL give LOCATION) ☒

**3. Name of child**

Baby Girl Statler

**5. Sex**

Female

**6. Twin or triplet**

—

**4. Date of birth**

September 19, 1947 Hour 8:28 P. M 20

**7. No. of weeks pregnancy**

40 weeks

**FATHER OF CHILD**

8. Full name Lawrence Richard Statler  
 9. Color white 10. Age at time of this birth 20 yrs.  
 11. Usual occupation laborer - Victor Products

**MOTHER OF CHILD**

12. Full maiden name Wanda Joan Mayhigh  
 13. Color white 14. Age at time of this birth 22 yrs.  
 15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1  
 (b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of None

19. Labor: (a) Complications of None  
 (b) Induced? No

20. (a) Was there an operation for delivery? Anesthesia  
 (Yes or No)

(b) State all operations, if any

(c) Did child die before operation? No

During operation? No

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Congenital heart disease - dysrhythmia

(b) Maternal causes None

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

Signature Robert F. Keadle M.D.  
 (Specify if M. D., midwife, or other)

Address

23. (a) B (b) Date thereof Sept 20, 1947  
 (Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Brown's Mill

24. (a) Funeral director A. E. Munn

(b) Address Greencastle Pa

25. (a) Sept 20, 1947 (b) Greencastle Pa  
 (Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)  
 The above certificate has been examined by me.

Health Officer, per

\* See Instruction C on stub.

Child lived 2 hrs. 27 min.

V. S. A10

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SEP 23 1947

BUREAU 78

Will you kindly complete  
The copy of this certificate  
Two words I can not  
read with certainty.

Chas. H. Bowers  
Loc. Reg.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08337

Reg. Dist. No. 300

## 1. PLACE OF DEATH:

County WashingtonCity or town Rural-Sharpsburg  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural-Sharpsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Carrie Evelyn Thomas

## 3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife X Reason--deceased

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

Oct. 21, 1889

8. AGE:

Years

57

Months

10

Days

23

If less than one day

hrs.

min.

9. Birthplace Downsville-Wash.-Maryland

(Town, county, and state)

10. Usual occupation

Home Duties

11. Industry or business

FATHER

12. Name

Charles Keets

13. Birthplace

Keedysville, Md

MOTHER

14. Maiden name

Martha Butler

15. Birthplace

Burketttsville, Md16. Informant Mrs. V. M. Knode

Address

Rural-Sharpsburg, Md

17. Burial (Burial, cremation, or removal. Which?)

Date thereof Sept. 16, 1947  
(month) (day) (year)

Cemetery or crematory

Red-Hill

Location

Rural-Keedysville

18. Funeral director

R. I. Earnshaw

Address

Keedysville, Md

19. (Date rec'd by registrar)

19 47

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1947 at 3:10 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 18, 1947 to Sept. 14, 1947  
and that I last saw him alive on Sept. 10, 1947

Immediate cause of death

DURATION

Carcinoma of liver.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

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OCT 8 1947  
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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1610

08338

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Wash. Co. Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Brownsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Main Street  
(If rural, give LOCATION)2.(a) If veteran, name war no

## 3. (a) FULL NAME

Thomas Andrew J. Jigant Tritapoe

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

Single

7. Birth date of

deceased (mo., day, yr.)

September 7 - 1947

8. AGE:

Years

Months

Days

If less than one day

hrs.

30

min.

9. Birthplace

Hagerstown Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

18. Cemetery or crematory

Location

19. Funeral director

Address

20. Date rec'd by registrar

19

47

Registrar

21. Signature

Address

Date signed

9/8/47

Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 19 47, at 1:50 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him live on 19 47, to 19 47

Immediate cause of death

DURATION

Asphyxia and anemia due toDue to maternal placenta previa

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Caesarean, ~~above~~

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. R. Ruler + Wells M.D.Address Hagerstown, Md.Date signed 9/8/47

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*Handwritten:* 2-10-47

**RECEIVED**

SEP 10 1947

**BUREAU OF**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The parent age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1510

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Now long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
903 Potomac Avenue  
 Now long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 903 Potomac Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Clinton Trovinger

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 8.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Mamie Trovinger 6.(c) If alive, give age 74 years  
 7. Birth date of deceased (mo., day, yr.) August 3, 1864  
 8. AGE: Years 83 Months 1 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Chewsville, Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Building Contractor  
 11. Industry or business

FATHER 12. Name Joseph Trovinger  
 13. Birthplace Leitersburg, Maryland  
 MOTHER 14. Maiden name Susan Yeakle  
 15. Birthplace Not Known

16. Informant Mrs. Clinton Trovinger  
 Address Hagerstown, Maryland

17. Burial Burial Date thereof 9-18-47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland

19. Sept. 17, 1947 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1947 at 6:30 A.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 to Sept. 16  
 and that I last saw him alive on Sept. 16

Immediate cause of death Coronary Vascular & Renal Disease DURATION July 5, 1947

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. \_\_\_\_\_

Autopsy results no  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide X X X Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE W. Howard Yeager M. D. or other  
Hagerstown, Md. Date signed 9-16-47

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

180

08340

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

28 yrs.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington

City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 49 W. Bethel Street  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Roy C. Clayton Walker

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

July 14, 1919

6. (c) If alive, give age. years

8. AGE:

Years

Months

Days

If less than one day

28

2

14

hrs.

min.

9. Birthplace

Hagerstown, Washington, Md.  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Roy C. Clayton Walker

13. Birthplace

Burkittsville, Md.

MOTHER

14. Maiden name

Daisy W. Kersner

15. Birthplace

Burkittsville, Md.

16. Informant

Mrs. Daisy Walker

Address

49 W. Bethel Street

17.

Burial  
 (Burial, cremation, or removal) Which?

Date thereof

9/29/47  
 (month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Md.

18. Funeral director

William H. Dawsey

Address

291 Frederick St. Hagerstown

19.

Sept. 29, 47  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1947, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 to 19

Immediate cause of death

3rd & 4th degree  
burns of entire body

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. 11/1

Autopsy results

no  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 9/28/47

Where did injury occur? Hagerstown, Wash. Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Burned in house Injured at work? No

23. SIGNATURE St. R. Thelwell DEPUTY MEDICAL EXAM.

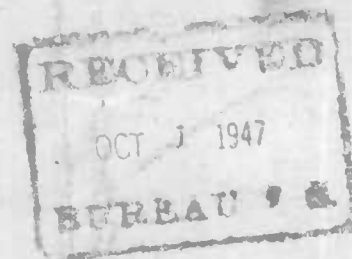
Hagerstown, Md. WASH. CO. MD.  
 Address Date signed 9/29/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08341

Reg. Dist. No. 302

## 1. PLACE OF DEATH

County Washington  
 City or town Capitol Hill and  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Week  
 Hospital institution or street address where death occurred:  
Washington Co Hospital  
 How long in hospital or institution? 1 Week

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Frederick  
 City or town Lantz Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. none  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war — ✓

## 3. (a) FULL NAME

Maurice Wilber Willard

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 8.(b) Name of husband or wife none  
 6.(c) If alive, give age — years  
 7. Birth date 8-27-1898 8-27-1898  
 deceased (mo., day, yr.)  
 8. AGE: Years 49 Months 11 Days — If less than one day — hrs. — min.

9. Birthplace Lantz  
 (town, county, and state)  
 10. Usual occupation Painter

## 11. Industry or business

MOTHER FATHER  
 12. Name Robert B. Willard  
 13. Birthplace Lantz Md  
 14. Maiden name Florence H. Willard  
 15. Birthplace Dearfield Fred Co Md

16. Informant Ray Willard  
 Address Smithsburg Md

17. Burial Date thereof 9-10-1947  
 (Burial, cremation, or removal, Where?) (month) (day) (year)

Cemetery or crematory Wm Pleasant  
 Location Near Smithsburg Md

18. Funeral director Geo. B. Hooper  
 Address Smithsburg Md

19. Sept. 8 19 47 Chas. H. Bowser  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Sept 19 47 at 6 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
1 Sept 19 47 to 8 Sept 19 47  
 and that I last saw him alive on 7 Sept 19 47

Immediate cause of death Pneumonia acute  
 Due to Pneumonia acute  
 Due to —  
 Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Edm. S. H. ...  
 M. D. or other —  
 Address 110 W. ... Date signed 8 Sept 47

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SEP 10 1947

BUREAU 88

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G. 115 APR 27 1948 (over) CERTIFICATE OF DEATH

Dr. Wells

08342

Reg. Dist. No. 308

## 1. PLACE OF DEATH:

County WashingtonCity or town \_\_\_\_\_  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? En route to Hagerstown

Hospital, institution, or street address where death occurred:

on U.S. # 40 10 mi West of Hagerstown, Ind.

How long in hospital or institution? \_\_\_\_\_

## 3. (a) FULL NAME

WILLIAM ROSS WILSON

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Velta

7. Birth date of

deceased (mo., day, yr.)

August 6 1901 19026. (c) If alive, give age 36 42 years

8. AGE:

Years

Months

Days

If less than one day

46 45028

hrs.

min.

9. Birthplace

Parkersburg Wood Co. W. Va.

(Town, county, and state)

10. Usual occupation

Filling Station Operator

11. Industry or business

FATHER

12. Name

John Wilson

MOTHER

13. Birthplace

Parkersburg W. Va.

14. Maiden name

Rose Kelley

15. Birthplace

Parkersburg W. Va.

16. Informant

Carroll A. Wilson

Address

Baltimore Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 9/6/47

(month) (day) (year)

Cemetery or crematory

Rose Hill Fair Lawn Cemetery

Location

Akron Ohio

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.19. Sept 4 19 47

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State OhioCounty SummitCity or town Akron

(If outside city or town limits, write RURAL and give nearest town)

Street No. 39 Fulton St

(If rural, give LOCATION)

None

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

298-01-9941

## MEDICAL CERTIFICATION

20. DATE OF DEATH

September 3 1947at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accidentDate of Sept. 3. 47

Where did injury occur?

Wardensburg RdPa.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means Auto struck by truck

Deputy med exam

23. SIGNATURE

J. Robert WellsWard Co. Md.

M. D. of

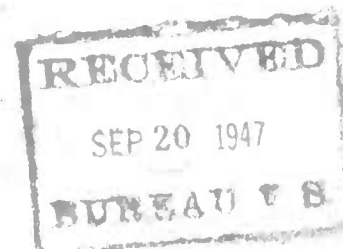
Address

Hagerstown, Ind

Date signed

Sept. 4. 47

Authorization for correction is made by John H. Coffman Atty. at Law at the request of  
Velta Wilson widow of deceased.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 144

## 1. PLACE OF DEATH:

County..... WashingtonCity or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Ritchie HospitalHow long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....City or town..... Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 9th Preston St  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Marie Rinegar Howshaw

## 3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

F White Married6. (b) Name of husband or wife..... Daniel B. Howshaw6. (c) If alive, give age..... 49 years7. Birth date of deceased (mo., day, yr.)..... May 19 19028. AGE: Years..... 45 Months..... 3 Days..... 25 If less than one day..... hrs. min.9. Birthplace..... New York  
(Town, county, and state).10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Daniel Rinegar13. Birthplace..... New York14. Maiden name..... Louise Fremaughton15. Birthplace..... New York16. Informant..... Hospital AdministratorAddress..... Victoria17. Transportation..... Sept 15 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... BataviaLocation..... State - New York18. Funeral director..... M. J. Cragg & SonAddress..... Thurmont, Md.19. Sept. 15 1947 Blanche L. Eiler  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 14 1947, at 7:58 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 1947, to Sept 14 1947, and that I last saw him alive on Sept 13 1947.Immediate cause of death..... Carcinomatosis, extensiveDue to..... Carcinoma of Breast DURATION..... 9 mos.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Thomas M. Arington, M.D.Address..... Ritchie Hosp. Crook, Md. Date signed..... Sept 14 1947

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 24 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 316

## 1. PLACE OF DEATH:

County Washington  
 City or town Keedysville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 60 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Keedysville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Henry Kyd Zimmerman

3.(b) Social Security Number  
None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Lillie M. ZimmermanB.(c) If alive, give age 62 years7. Birth date of deceased (mo., day, yr.) June 4, 1882

8. AGE: Years 65 Months 3 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Sharpsburg-Wash.-Maryland  
(Town, county, and state)10. Usual occupation Merchant

11. Industry or business

FATHER 12. Name Nicodemus Zimmerman13. Birthplace Eagle's Mill, MdMOTHER 14. Maiden name Rosanna Snyder15. Birthplace Eagle's Mill16. Informant Mrs. Lillie ZimmermanAddress Keedysville, Md17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Sept. 30, 1947  
(month) (day) (year)Cemetery or crematory Fair-ViewLocation Keedysville, Md18. Funeral director R. I. EarnshawAddress Keedysville, Md19. Sept 30 1947 R.I. Earnshaw  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 19 47, at 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18 19 47 to Sept. 28 19 47, and that I last saw him alive on Sept. 27 19 47.

Immediate cause of death Cerebral Proliferation DURATION 7 mos.

Due to Chronic Nephritis 7 mos.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R. I. Earnshaw M. D. or otherAddress 1 Earnshaw, Md. Date signed 9/29/47

RECEIVED

OCT 3 1947

BUREAU